VERMONT

DOL FORM 13 (Rev. 5/05)
State File No. _____
Ins. Co. File _____
Date of Injury _____
Fed. ID No. _____

DEPARTMENT OF LABOR
WORKERS' COMPENSATION DIVISION

REPORT OF BENEFITS AND RELATED EXPENSES PAID

EMPLOYEE: _____ (a) SOCIAL SECURITY NO.: _____ (b)

EMPLOYER: _____ (c) NCCI CLASS CODE: _____ (d)

INS. CARRIER: _____ (e) CONTACT PERSON: _____ (f)

ADJUSTING CO. (if different from carrier): _____ (g)

REPORT TOTAL EXPENSES PAID TO DATE FOR THIS CLAIM. Date Completed. _____

VOCATIONAL REHABILITATION

Contractual (VR Vendor) **$** _____ (h) Benefits Paid **$** _____ (i)

LEGAL - Defense (Contractual) **$** _____ (j) Plaintiff (Lien) **$** _____ (k)

MEDICAL **$** _____ (l)

TEMPORARY TOTAL DISABILITY

From _____ To _____ @ **$** _____ Total Weeks _____ Days _____

From _____ To _____ @ **$** _____ Total Weeks _____ Days _____ **$** _____ (m)

TEMPORARY PARTIAL DISABILITY

From _____ To _____ @ **$** _____ Total Weeks _____ Days _____

From _____ To _____ @ **$** _____ Total Weeks _____ Days _____ **$** _____ (n)

PERMANENT PARTIAL DISABILITY

LUMP SUM ADVANCES Date _____ Amount **$** _____

From _____ To _____ @ **$** _____ Total Weeks _____ **$** _____ (o)

PERMANENT TOTAL DISABILITY

From _____ To _____ @ **$** _____ Total Weeks _____

From _____ To _____ @ **$** _____ Total Weeks _____ **$** _____ (p)

FATALITY (Spouse/Dependent Benefits)

From _____ To _____ @ **$** _____ Total Weeks _____ **$** _____ (q)

FUNERAL (Including payment to the 2nd Injury Fund, if appropriate) **$** _____ (r)

SETTLEMENT AGREEMENTS (Check One) 14 ☐ 15 ☐ 16 ☐ **$** _____ (s)

EACH BLANK MUST BE COMPLETED. USE N/A WHERE APPROPRIATE.